STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	6021 North Lidgerwood Spokane, WA 99207

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure a resident remained free from sexual abuse for 1 of 3 sampled residents (Resident 1), reviewed for abuse. This placed residents at risk for sexual abuse and psychosocial harm. Findings included . Review of the admission assessment, dated 04/06/2026, showed Resident 1 was admitted with diagnoses to include neurological and seizure disorders. Resident 1 was cognitively intact, able to make their needs known and was dependent for most Activities of Daily Living. Review of the facility investigation, dated 06/01/2026, showed Resident 1 approached Staff B, Registered Nurse and stated Staff A, Certified Nursing Assistant, was a sexual predator and the facility needed to get rid of them. Staff B asked Resident 1 what they meant and Resident 1 stated Staff A made sexual statements about their body and what they would do sexually to them. Resident 1 said what kind of perverse person says those things to somebody that can't take care of themselves. Resident 1 told Staff B they were concerned about themselves, along with other female residents in the facility. Staff B reported the allegation to Staff D, Interim Director of Nursing, Staff A was immediately suspended, and an investigation was started. Staff A was later terminated after the facility substantiated abuse. During an interview on 06/03/2026 at 1:25 PM, Resident 1 was sitting up in their wheelchair. Resident 1 stated Staff A said sexual things to them over the period of 3 weeks. Resident 1 stated they thought Staff A was joking, but realized they weren't jokes, and they reported the concern to Staff B. Resident 1 stated Staff A had never touched them and only made sexual comments towards them. When asked if they felt safe, Resident 1 stated now that Staff A was no longer at the facility, they did feel safe. On 06/18/2026 at 1:10 PM, Staff C, Social Services Director, stated they interviewed Resident 1 after the allegation was reported. Resident 1 reported they were sorry they hadn't reported Staff A sooner, but thought Staff A was joking. Resident 1 did not feel fearful since Staff A was no longer at the facility. Staff C checked on Resident 1 for multiple days after the incident and they did not show any signs of psychosocial harm. On 06/18/2026 at 2:25 PM, Staff D stated they were made aware of Staff A's sexual statements from Staff B. The investigation was started immediately and Staff B was suspended during the investigation. The investigation substantiated abuse and Staff A's employment was terminated. Reference: WAC 388-97-0640(1)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE